

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011710

STATE FILE NUMBER

FILED APR 14 1959

Registration District No.

317

Primary Registration District No.

547

Registrar's No.

970

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Heights		c. CITY OR TOWN Kirkwood 22	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hosp.		d. STREET ADDRESS (If outside, give location) 1009 Ormond	
3. NAME OF DECEASED (Type or print) First Middle Last CLYDE WILLIAM COPELAND		4. DATE OF DEATH Month Day Year April 7, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 10, 1905
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dist. Credit Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Int. Harvester	11. BIRTHPLACE (City and state or country) Ellington, Mo.
13a. FATHER'S NAME L. J. Copeland		14. NAME OF HUSBAND OR WIFE Jewel E. Copeland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) None		16. SOCIAL SECURITY NO. 493-07-0991	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw him alive on _____ Death occurred at 10:30 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Daniel P. Peyton M.D.	
22b. ADDRESS 634 N. Grand Ave.		22c. DATE SIGNED 4-9-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Apr. 10, 1959	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cem.	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
24. FUNERAL DIRECTOR Pfitzinger Mort-Kirkwood		25. DATE RECD. BY LOCAL REG. 4-9-59	
26. REGISTRAR'S SIGNATURE John E. Murphy M.D.			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Ben E. Hoffman*

Licensed Embalmer No. *4266*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.